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HEALTH INSURANCE
(Kenko Hoken)

PUBLIC HEALTH AND WELFARE TECHNICAL BULLETIN

PH&W GHQ SCAP APO 500 March 1949

1. Introduction -

a. This is the second in a series of Technical Bulletins to be issued by Public Health and Welfare Section, SCAP, on the Japanese social insurance laws and ordinances, giving specific information on the administration of such laws, and providing suggested guide sheets for the convenience of the Military Government Teams. The first of the series, issued in December 1948, concerned National Health Insurance.

b. Attahced Inclosure #1 is an English translation of the Health Insurance Law, Inclosure #2 is a copy of Enforcement Regulations prescribed by Cabinet Order and Inclosure #3 is a suggested guide sheet for use in reviewing the administration of society-managed health insurance in a prefecture. An English translation of Enforcement Regulations and forms prescribed by Ministerial Ordinance is now being prepared and will be released at a later date. Guide sheets for reviewing government-managed health insurance will be incorporated in a subsequent Technical Bulletin concerning the operations of prefectural insurance sections and the social insurance branch offices.

2. Summary of Program -

a. General Scope:

Health Insurance in Japan is an integral part of the Japanese social insurances which have been in effect for a number of years. It applies chiefly to industrial, commercial, mining, and transportation workers and provides benefits for medical and allied care arising from non-occupational causes. It may also apply to the employees of a government office or juridical person or to employees of an employer not otherwise covered who with the consent of one-half or more of his employees elects to have such insurance. It is effected and controlled by the Health Insurance Law of 1922 (effected in 1927) and subsequent admendments thereto, and is compulsory for all regular full-time employees in the respective categories of employment in establishments or offices of five or more employees. It is financed in the main by monthly contributions from employers and employees, based with limitations on the amount of wages paid and received.

Latest amendments to the Law were made in July and December, 1948. New appeal, penalty, coverage, and administrative provisions were added in July, and under the amendments, coverage, as of April 1, 1949, will be extended to Japanese workers employed by the Japanese Government for the Occupation Forces. In December a single amendment was made which increased the limit of the standard remuneration of an insured person from a maximum class scale of 8,100 Yen monthly, as the highest amount subject to contribution, to 13,800 Yen monthly. The lowest class scale remained unchanged at 300 Yen monthly.

The primary responsibility for the administration of the Health Insurance Law is vested in the Ministry of Welfare, with provision for two distinct types of management: namely: government-managed health insurance and society-managed health insurance. The basic differences in these types of management, which will be treated in subsequent paragraphs, is that government-managed health insurance usually applies to employees in establishments or working places which employ less than 500 workers and is under full government control while society-managed, which may be effected in establishment of 300 or more workers, is chiefly under the control of the society concerned.

b. Benefits:

Benefits under the Law for insured members cover medical and dental services and cash allowances for sickness and injury arising from non-occupational causes; medical services and cash allowances for maternity, delivery, nursing, and funeral expense; and cash repayments for amounts expended by the insured for services. The amount of cash allowances paid during periods of sickness or incapacity varies according to the standard monthly remuneration of the insured. The amount of cash benefit for repayment of medical service costs, expended by an insured for service from a private doctor, is determined by prescribed rates. The same type of benefits, excluding cash allowances, are provided for the dependent of an insured member; however, the insurer will allow to the insured member only 50% of the cost of such dependent's benefits at prescribed rates and the insured member must pay the balance of such cost.

c. Financing:

Employee contributions in government-managed health insurance are limited by the law to a maximum of 2.2% of their standard monthly remuneration and in the society-managed type to 2.5%. An employer's contribution each month must equal his employee contributions, but the employer is not prohibited from making additional contributions if he so desires. Other income available for health insurance activities may arise from donations, fees for service to non-insured persons, investments,

and from limited government subsidies. Employee contributions are collected through payroll deductions in both types of management and it is the responsibility of the employer concerned to make such deductions.

d. Government-management:

The government-managed type of health insurance is for persons employed in establishments having 5 or more but less than 500 workers; however, an establishment of 300 or more employees may be granted authority to operate a health insurance program. This authority demands that such smaller establishments have the proper facilities for carrying on an adequate program, and in actual practice establishments that employ over 500 workers may remain under government-management for a considerable period before a society-managed plan is approved.

In the government-managed type the government is the insurer and conducts its business through the Insurance Section of the Prefectural Welfare Department. In these operations contributions are sent by the employer to the National Government through the Prefectural Insurance Section and appropriations for the payment of benefits, medical care claims, and business operational costs are forwarded by the National Government to the Prefectural Insurance Section for disbursement. In a prefecture, where conditions warrant, a branch office of the Prefectural Insurance Section may be established to permit more efficient and convenient operations of the program.

Medical facilities used in the government-managed type may be owned by the Ministry of Welfare, privately owned and under contract to the government, or privately owned and made available for insured members. The insured members receive medical service from appointed or private doctors, or from staff doctors of the government owned or operated facilities, upon presenting valid membership certificates issued by the Prefectural Insurance Section through the employers to the insured members. The certificates are prepared from employee listings supplied to the Insurance Section by the employers concerned. Statements from insurance doctors for services rendered to insured members and their dependents were formerly paid by the Insurance Section but are now to be paid by the branch office of the Medical Fee Payment Fund established in the area. Services obtained from other than insurance doctors by insured members are payable by the insured members with subsequent reimbursement by the Insurance Section, according to amounts allowed by the Law. The services available under the government-managed type to the insured members and their dependents are specified in the Law.

e. Society-management:

The society-managed type is primarily for single establishments or a combination thereof which regularly employ 500 or more workers. An establishment that employs 300 to 500 workers may, with the approval of govern-

ment officials, voluntarily form a health insurance society and administer its own health insurance program. For an establishment that regularly employs 500 or more full-time workers it is obligatory that such concern organize and operate a health insurance society for its employees, although such operation may be deferred by governmental action and the employees remain under government-managed insurance until a society can be properly formed.

In the society-managed type the policies and administration of the society are determined and directed by a society council and a board of directors. These guiding bodies are formed by members of the society with equal representation for management and workers. Thus it is to a marked degree autonomous. The society council is composed of a fixed number of councillors, with a two year term of office, and is so organized that it contains half of its councillors appointed by the employer and half elected by the workers. The fixed number of councillors is determined by the society concerned. In a similar manner the board of directors of the society is composed of a fixed number of directors half of which are elected by the councillors representing employer interests and half by councillors representing worker interests. The authority of the board of directors is usually limited to administrative matters but may, under certain circumstances, extend to councillor duties, especially when a new council is being formed or when a council is not in session.

In the society-managed type the society acts as the insurer and conducts all necessary business to effect a health insurance program for its members. Its operations, however, are subject to the approval of government officials and its affairs and records are subject to periodic inspection and audit. It must submit regular monthly and annual reports to proper government offices.

Medical facilities of the societies are usually owned and operated by the employers concerned and the society is charged for the usage. It is possible, however, for a society to own and operate its own facilities and to extend to non-insured persons in the community such services as it may be able to provide. In addition to the medical service personnel that may be employed on a full-time basis by a society, insurance doctors appointed upon their own request by the prefectural governor are available to the insured members, or the members may obtain the services of a private doctor. The benefits provided by the societies are as stipulated in the Law and in addition they may be augumented by other services if the society so elects and has the resources to furnish such additional services.

f. Rights of Interested Parties:

The law provides all interested parties adequate rights of appeal through an insurance referee in each prefecture and further appeal or mediation through a Health Insurance Appeals Board established at the national level. Appeals may be made on the assessment or payment of

contributions, the determination and payment of insurance benefits, the administration of the Law, the formation of official bodies managing the affairs of the health insurance program, and other issues, and mediation may be requested and obtained on controversies between the insured, the insurer, and doctors. Appeals are made initially to the Insurance Referee in the prefecture and may be carried higher to the Health Insurance Appeals Board, and thence be made the cause of a lawsuit. Requests for mediation are made through the prefectural governor to the Health Insurance Appeals Board. The Law further provides penalties for administrative irregularities, abuses, and infringement, for the protection of interested parties.

3. Current Problems -

In general the administration of health insurance is comparatively free of the present reformation difficulties that prevail in the National Health Insurance program; however, economic conditions have caused curtailment in the development of adequate service facilities and created a lack of surveillance by managing personnel. This in turn has caused deliquencies in contributions and a lack of proper accounting and reporting procedures.

4. Major Objectives -

Major objectives to be attained in reviews of organizations administering health insurance are those that give encouragement to good administrative practices, according to democratic concepts, and place specific accent on the following:

a. The collection of deliquent accounts.

b. The establishment of prompt contribution collections and payments by employers.

c. The development of good informational programs for the insured.

d. The improvement of medical facilities and services.

e. The adoption of sound financial policies and practices.

f. The adoption of prompt and accurate reporting techniques.

g. The development of good relations with doctors, dentists, pharmacists, and nurses.

h. The prompt payment of medical charges, including prompt deposits in the Medical Fee Payment Fund.

i. The conduct of fair hearing on appeals and mediations.

j. The development of cooperation and coordination between the employers and the Prefectural Insurance officials.

3 Inclosures:

Inclosure #1: Health Insurance Law.

Inclosure #2: Enforcement Regulations of the Health Insurance Law.

Inclosure #3: Guide for a Review of A ociety Administering Health Insurance (Kenko Hoken).

English Translation of the Japanese

HEALTH INSURANCE LAW

(Law No. 70 of April 22, 1922, as amended during 1926, 1929, 1934, 1939, 1941, 1942, 1944, April 1947, December 1947, July 3 1948, and December 27, 1948)

25 February 1949

The Social Security Division

PHW GHQ SCAP

Incl. 1

THE HEALTH INSURANCE LAW

(Law No. 70 of April 22, 1922, as amended during 1926, 1929, 1934, 1939, 1941, 1942, 1944, April 1947, December 1947, July 3, 1948, and December 27, 1948) 1/

Chapter I - General Provisions

Article 1. Health insurance shall provide for the payment of benefits to insured persons and to persons supported by them (hereinafter referred to as "dependents") in case of sickness, injury, death, or maternity attributable to causes or sources outside of their employment.

The term "dependents" mentioned in the foregoing paragraph signifies lineal ascendants, spouses (as used throughout this Law includes persons who live together as husband and wife without formal marriage), children of insured persons who are mainly supported by them, and persons who live in the same household and are mainly supported by the insured.

Article 2. The term "remuneration" in this Law signifies the wages, pay, salary, allowances, or bonuses which are received in cash or in benefits in kind by employees from employers as compensation for services performed; however, this provision shall not be applied to such remuneration as may be received at extraordinary intervals nor to an allowance or bonus received less regularly than every three months.

If the whole or part of the remuneration received is in benefits in kind, the cash value thereof shall be fixed, according to the current prices in the district concerned, by the prefectural governor.

In addition to the provisions of the foregoing paragraph, special provisions applying to remuneration may be made by the Health Insurance Societies in their articles.

Article 3. Health insurance contributions and benefits shall be calculated on the standard remuneration of insured persons.

The amount of standard remuneration of an insured person shall be determined on the basis of the monthly amount of the insured person's remuneration in accordance with the classes prescribed in the following table:

1/ Annotations are added to this translation to supply explanatory comment not contained in the Japanese text.

Classification of Standard Remuneration Class	Standard Remuneration Monthly	Daily	Monthly Value of Remuneration Less than	The same as or more than
1st	300	10	450	- 0
2nd	600	20	750	450
3rd	900	30	1,050	750
4th	1,200	40	1,350	1.050
5th	1.500	50	1,650	1,350
6th	1,800	60	1,950	1,650
7th	2,100	70	2,250	1,950
8th	2,400	80	2,550	2,250
9th	2,700	90	2,850	2,550
10th	3,000	100	3.150	2,850
11th	3,300	110	3,450	3,150
12th	3,600	120	3,750	3,450
13th	3,900	130	4.050	3,750
14th	4,200	140	4,350	4,050
15th	4,500	150	4,650	4,350
16th	4,800	160	4,950	4,650
17th	5,100	170	5,250	4,950
18th	5,400	180	5,550	5,250
19th	5,700	190	5,850	5,550
20th	6,000	200	6,150	5,850
21st	6,300	210	6,450	6,150
22nd	6,600	220	6,750	6,450
23rd	6,900	230	7,050	6,650
24th	7,200	240	7,350	7,050
25th	7,500	250	7,650	7,350
26th	7,800	260	7,950	7,650
27th	8,100	270	8,250	7,950
28th 1/	8,400	280	8,550	8,250
29th	8,700	290	8,850	8,550
30th	9,000	300	9,150	8,850
31st	9,300	310	9,450	9,150
32nd	9,600	320	9,750	9,450
33rd	9,900	330	10,050	9,750
34th	10,200	340	10,500	10,050
35th	10,800	360	11,100	10,500
36th	11,400	380	11,700	11,100
37th	12,000	400	12,300	11,700
38th	12,600	420	12,900	12,300
39th	13,200	440	13,500	12,900
40th	13,800	460	-	13,500

1/ Classes 28 through 40 were added by amendment of December 27, 1948, and became effective January 1, 1949.

The determination of the amount of standard remuneration of an insured person shall be made as of the date when the insured person is qualified as insured.

When the subsequent remuneration of an insured person is not in the same class as that used to determine his standard remuneration classification, because the remuneration of the said insured has been increased or decreased during a subsequent month, the standard remuneration of said insured shall be revised at the beginning of the following month; however, if the date of change in the remuneration of said insured was the first day of the month, the revision of the standard remuneration of the insured shall be effective from the beginning of the same month.

The standard remuneration of an insured person, insured according to the provision of Article 20, shall not be changed.

Article 3-2. The monthly standard remuneration of insured persons shall fixed in accordance with the provisions of the following sub-paragraphs:

1. When the remuneration is determined by the month, week, or other definite period, it shall be calculated by dividing the total amount of the remuneration determined as of the date on which the insured qualified, or the date on which his remuneration was increased or decreased, by the total days during that period, multiplied by 30.

2. When remuneration is regulated by days, hours, output, or the contract of a person entitled to insurance, monthly remuneration will be the same as the average amount of the monthly remuneration of persons engaged in the same kind of business or work in the same working place and who received the same kind of remuneration for the month immediately preceding the month in which the insured persons became qualified as insured.

When the monthly remuneration of an insured person has been determined in accordance with the preceding paragraph and his remuneration has subsequently increased or decreased, the amount of monthly remuneration shall be based on the remuneration received on the day when the change in remuneration occurred.

3. If the remuneration cannot be calculated by the preceding two provisions, the monthly remuneration of the insured person shall be the same as the remuneration received by another person who is engaged in the same kind of business or work in the same district and who received the same kind of remuneration

during one month before the day when the insured person qualified or when the remuneration of the insured person was increased or decreased.

4. If the insured person receives remuneration which comes under more than one of the preceding provisions of this article, the sum total of the values calculated under each of the said provisions shall be the monthly remuneration of the insured person.

5. If the insured person receives remuneration from two or more business offices for the same period, the sum total of the value calculated under each of the said provisions with regard to each office shall be the monthly remuneration of the insured person.

If the monthly value of the remuneration of the insured person cannot be calculated under the preceding provisions or if the value calculated under the preceding provisions is inequitable, despite the said provisions, the insurer shall calculate the monthly remuneration of the insured person by other methods.

Whenever an insurer is a Health Insurance Society, methods of calculating remuneration, other than those mentioned in the preceding paragraphs, may be prescribed in the articles of the Society.

Article 4. The right to charge contributions and other assessments provided in this Law and the right to refunds and to benefits are cancelled by prescription after two years have elapsed.

Civil Code regulations on prescription and the interruption and suspension of prescription, stated in the preceding paragraph, shall be applicable to the rights of employer, insurer, and insured persons under Health Insurance.

In accordance with the provisions of Ministerial Ordinance, notifications by the insurer made on the charge of contributions and other assessments prescribed in this Law possess the validity of interruption of prescription regardless of Article 153 of the Civil Code.

Article 5. In regard to the calculation of the period of time prescribed in this Law and in ordinances issued upon this Law, regulations of the Civil Code concerning calculation of time shall govern.

Article 6. Stamp duty shall not be levied on Health Insurance documents.

No income tax or juridical person tax shall be assessed on a Health Insurance Society.

No local municipal body shall be authorized to impose a local tax on the operations of a Health Insurance Society.

Article 7. An insurer or beneficiary may demand a certification of the census registration of an insured person, or person previously insured, from the official in charge of census registration or his deputy, without charge.

In granting benefits stated in paragraph 2 of Article 1, the preceding regulation is applicable to the census registration of dependents or former dependents.

Article 8. The insurer may, as provided by Ministerial Ordinance, require employers of insured persons to report on employee changes, remuneration, and other matters, or present pertinent documents thereon and otherwise administer affairs necessary for the enforcement of Health Insurance.

Article 8-2. The insurer may, as provided by Ministerial Ordinance, require the insured or those who are eligible to receive a benefit to submit an application, report, or document to their insurer or employer necessary for the execution of Health Insurance.

Article 9. The authorized government office, when it considers it necessary, may have an authorized person question those concerned at the place of employment of insured persons and inspect accounts, documents, and other papers at the place of employment with respect to the changes and the remuneration of insured persons and the decisions on benefits.

Article 9-2. With respect to benefits, the authorized government office may have an authorized person inspect records on medical care and other documents.

Article 10. The Welfare Minister may delegate, by order, a part of his official powers prescribed in this Law to the prefectural governor.

Article 11. In the case of non-payment of contribution and other assessments prescribed in this Law, the insurer shall designate the time limit for payment and make demand for payment.

When a demand for payment is necessary, in accordance with the preceding paragraph, an insurer shall issue a demand letter to an employer who is under obligation to pay. In such case 10 Yen shall be charged as the demand fee.

When a demand letter is issued, according to the preceding paragraph, penalty on the amount due shall be assessed for the number of days from the day after the date when payment was due to the day before the full payment of charges or the attachment of property, at a rate of 5 Sen per day for each 100 Yen charged. If, however, the deliquent case comes under any of the following, or if extenuating circumstances regarding arrearage are recognized, this rule shall not be applied:

1. The assessed amount in a demand notice is less than 100 Yen.

2. The time of payment is advanced and collection is made.

3. The demand notice or demand letter for payment is made by the same method as used in sending an official notice when the address and domicile of one who is under obligation to pay is not within Japanese territory, or his address and domicile are not clear.

When the contributions and delinquency fee are fully paid within the term fixed in the demand letter, or when the total counted by the preceding paragraph is less than 1 Yen, the penalties shall not be collected.

Article 11-2. When employers who receive demands for payment, as prescribed in the preceding article, fail to pay their contribution and other assessments prescribed in this Law in the designated time, the insurer may take further action according to the process for the collection of taxes in arrears or may demand such action of the city, town, or village where the defaulters live or their property lies; however, when a Health Insurance Society is the insurer, collection by disposal of property, according to the process for the collection of taxes in arrears, is allowable only when disposal has been demanded of the city, town, or village concerned and the letter has failed to institute such action within 30 days from the day of its receiving the demand or when it has failed to complete it within 90 days.

Approval by the Welfare Minister is required when a Health Insurance Society disposes of an employer's property according to the process for the collection of taxes in arrears prescribed in the proviso of the preceding paragraph.

When the insurer demands action of a city, town, or village in accordance with paragraph 1, the city, town or village will make the disposition in accordance with the taxation procedure of the city, town, or village. When the city, town, or village concerned makes the collection for the Society, the city, town or village will receive four per cent of the amount collected.

The terms "towns" and "villages" in paragraph 1 and in the preceding paragraph are applicable to those districts not organized as towns or villages.

Article 11-3. The precedence of contributions and other assessments prescribed in this Law is second in priority to the assessments of cities, towns, villages, or associations of local public bodies 1/ but precedes other public imposts.

Article 11-4. With respect to the delivery of documents concerning contributions and other assessments prescribed in this Law, Articles 4-7 and 4-8 of the National Tax Collecting Law shall govern.

Article 12. When a person is employed by the government or is employed by an office of a local public community and is a member of a Mutual Aid Association, in accordance with the National Public Service Mutual Aid Law, he shall not be entitled to the benefits profided by this Law.

The kind and degree of benefits of the said Mutual Aid Association are equal to or above the benefits provided by this Law. 2/

Article 12-2. With respect to a Mutual Aid Association, as described in the preceding article, the Welfare Minister may require such Association to report operations, issue instructions on the management of the Association, and inspect conditions and property of the Association. 3/

Article 12-3. Contributions for Health Insurance shall not be collected from those ineligible for Health Insurance benefits by reason of Article 12.

Chapter II. Persons Insured.

Article 13. All persons who are engaged in employment in working places (as used throughout this Law includes offices) within the following categories shall be insured under Health Insurance:

1. Working places which regularly employ five or more persons engaged in:

1/ Article 284 of Local Autonomy Law defines "local public bodies".
2/ Entered in the Japanese text as a notation.
3/ Similar provision in Article 9, paragraph 2, NPSMAA Law.

a) The manufacture, alteration, selection, packing, repair, or demolition of articles;

b) Mining, quarrying, or other processes for the extraction of minerals from the earth;

c) The generation, transmission, and supply of electricity and other motive power;

d) The transport of passengers or freight;

e) The loading and unloading of freight;

f) The sale and distribution of goods;

g) Finance or insurance;

h) The storange or loan of goods;

i) The brokerage of any kind of goods or services;

j) Guide service, advertising, or the collection of money;

k) Incineration, sweeping, or butchery.

2. An office of government or juridical person which regularly employs five or more persons.

Article 13-2. Persons who come under any of the following sub-paragraphs, irrespective of other provisions of the Law, shall not be insured under Health insurance.

1. Persons insured under Seaman's Insurance (excluding those designated in Article 20, paragraph 1, of the Seamen's Insurance Law).

2. Persons employed temporarily:

a) Persons employed for not more than the contract period of two full months;

b) Persons employed on a daily basis.

If, however, a person excluded by sub-paragraph (a) is employed continuously beyond the designated time or if a person excluded by sub-paragraph (b) is employed continuously beyond one month, the provisions of such sub-paragraphs shall not be applicable.

3. Persons engaged in seasonal work, excluding persons intended to be employed continuously beyond four months.

4. Persons employed by establishments engaged in temporary enterprises, excluding persons, intended to be employed continuously beyond six months;

5. Persons employed by working places or offices when such working places or offices have no fixed location;

6. Persons employed by a National Health Insurance Association or by a corporate juridical person administering National Health Insurance;

7. Persons employed by a life insurance company as solicitors for life insurance and who receive commissions instead of a fixed amount of remuneration.

When a person insured under Health Insurance in accordance with the preceding article becomes insured under National Health Insurance, with the approval of the insurer, or with the approval of the Mutual Aid Association as prescribed in Article 12, such person shall not be insured under Health Insurance during such period.

Article 14. Employers engaged in undertakings not designated in Article 13 may apply for the approval of the Welfare Minister to have all of their employes insured under Health Insurance.

In applying for the approval prescribed in the preceding paragraph the consent of one-half or more of all employees of the working place shall be necessary.

Article 15. When the approval prescribed in the preceding article is granted, such employees will be insured under Health Insurance.

The provisions of Article 13-2 shall serve to preclude approval.

Article 16. If a business of the type listed in Article 13 ceases to be subject to the provisions of such article it shall be considered as having been granted the approval prescribed in Article 14.

Article 17. Persons insured in accordance with the provisions of Articles 13 or 15, are insured as of the first day of employment or on the day when the provisions of Article 13-2 or Article 15, paragraph 2, become inapplicable to them.

Article 18. Persons insured in accordance with the provisions of Articles 13 or 15 are disqualified as insured on and after the day

following the date of death, severance of employment, or when Article 13-2 or Article 15, paragraph 2, becomes applicable to them. However, if the provisions of the preceding article become applicable on the date of severance of employment, or when Article 13-2 or Article 15, paragraph 2, becomes applicable to them, they are disqualified as of that day.

Article 19. Employers of persons insured according to Article 15 may apply for the approval of the Welfare Minister to have all such insured persons disqualified as insured.

In applying for the approval prescribed in the preceding paragraph, the consent of not less than three-fourths of the persons insured is necessary.

When the approval prescribed in paragraph 1 has been granted the persons insured are disqualified as of the day following the approval.

Article 20. Any insured person disqualified by reason of Article 18 may continue to be insured providing he makes application to the insurer not later than ten days after the date of disqualification or, in case the insured person is receiving benefits at the time of disqualification, if he makes application not later than ten days after the termination of the period in which he is receiving benefits, providing further that such person has been insured for more than two months prior to the date of disqualification. However, those insured by Seamen's Insurance (excluding those designated in Article 20, paragraph 1, of the Seamen's Insurance Law) shall be excepted from this rule.

An application presented later than as prescribed in the preceding paragraph may not be accepted without proper reason being given by the insured.

Article 21. If a person, in accordance with the preceding article, comes within the provisions of the following sub-paragraphs he shall be disqualified as of the following day. However, with respect to sub-paragraphs 4 and 5 he shall be disqualified as of that day.

1. After the lapse of six months from the date he became insured;

2. In the event of death of the insured;

3. If the insured does not pay the total contributions within ten days after the specified date on which contributions are due;

4. If the insured person becomes insured as provided by Articles 13 or 15 of this Law;

5. If the insured becomes insured by Seamen's Insurance (excluding those designated in article 20 of the Seamen's Insurance Law).

Chapter III. The Insurer.

Article 22. An insurer under the Health Insurance Law shall be either the Government or a Health Insurance Society.

A Health Insurance Advisory Council shall be established to consider important affairs concerning the operation of health insurance by the Government.

The members of the Health Insurance Advisory Council shall be appointed by the Welfare Minister and shall consist of an equal number of those who represent the insured, the employer, and the public interest.

In addition to the provisions stipulated in the preceding two paragraphs, other necessary matters concerning the Health Insurance Advisory Council shall be prescribed by Cabinet Order.

Article 23. The insurer may provide suitable facilities necessary for the treatment of sickness or injury and the improvement of the health of insured persons and their dependents, and shall pay the necessary expenses thereof.

Article 23-2. The insurer may allow persons other than the insured and their dependents to utilize the facilities mentioned in the preceding article only when such use will not impair the intended function of such facilities.

The insurer may demand fees in accordance with Ministerial Ordinance from those availaing themselves of these facilities.

Article 24. The Government shall manage Health Insurance for insured persons who are not members of a Health Insurance Society.

Article 25. A Health Insurance Society shall manage Health Insurance for insured persons who are members of the Society.

Article 26. A Health Insurance Society shall be a juridical persons.

Article 27. A Health Insurance Society shall be composed of employers and insured employees.

Article 28. An employer regularly having 300 or more employees in one or more working places may form a Health Insurance Society.

Two or more employers of insured employees may jointly form a Health Insurance Society. In such case the combined number of insured persons shall regularly number 300 or more.

Article 29. The consent of half or more of those persons to be insured who possess the qualifications to be members of the Society shall be obtained to form a Health Insurance Society. Articles of the Society shall be drawn up and the approval of the Welfare Minister shall be obtained.

Whenever a Health Insurance Society is to be formed that covers two or more working places the consent prescribed in the preceding paragraph shall be obtained from the employees of each working place.

Article 30. The term "insured person" in the preceding two articles shall also include those persons to be insured when application for approval of the formation of a Health Insurance Society and application for the approval prescribed in Article 14, paragraph 1, are made at the same time.

Article 31. The Welfare Minister may order the formation of a Health Insurance Society by an employer regularly having 500 or more insurable employees, as defined in Article 13, in one or more working places.

Article 32. The employer who has been ordered to form a Health Insurance Society shall draft articles for the Society and obtain the approval of the Welfare Minister for the formation of the Society.

Article 33. Deleted.

Article 34. A Health Insurance Society is officially authorized when approval is granted for its formation.

Article 35. When a Health Insurance Society is formed the employer and all the insured employees of the working place become its members.

Article 36. An amendment to the Articles of a Health Insurance Society does not become effective until such amendment is approved by the Welfare Minister.

Article 37. The Welfare Minister may require a Health Insurance Society to submit reports on its affairs, inspect the conditions of its

business and its funds, order amendment of the Articles of the Society, and make other necessary changes in the administration of the Society.

Article 37-2. The Welfare Minister may through Ministerial Ordinance require the installation of insurance facilities and the payment of expenses thereof, as prescribed in Article 23.

Article 38. When the officers of a Health Insurance Society are absent, not available, or in difficulties, or if the Society fails to provide benefits or perform other duties, the Welfare Minister may appoint government officials and others to discharge the duties of the Society.

In circumstances described in the preceding paragraph the expenses necessary for the discharge of such duties shall be borne by the Health Insurance Society.

Article 39. When a determination of a Health Insurance Society or the conduct of an officer is contrary to law, or to the directions of the Welfare Minister, as prescribed by law, or to the Articles of the Society, and it is recognized to be harmful to the interests of the members of the Society, or when continued existence of the Society is considered to be difficult in view of the condition of the Society's finances and property, the Welfare Minister may revoke the determination, discharge the officers, or order the dissolution of the Society.

Article 40. The assets and liabilities of a Health Insurance Society which has been dissolved shall be assumed by the Government.

Article 41. Matters concerning the administration, partition, amalgamation, or dissolution of a Health Insurance Society, the custody and use of the Society's property, and other necessary matters referring to the Health Insurance Society, not provided in this Law, shall be prescribed by Cabinet Order.

Article 42. The insurer of an insured person who is employed by two or more employers at the same time shall be designated by the Welfare Minister.

Article 42-2. Health Insurance Societies may jointly form a Health Insurance Federation to accomplish their mission.

A Health Insurance Federation shall be a juridical person.

In establishing a Health Insurance Federation, Articles of the Federation shall be drafted and approval obtained from the Welfare Minister.

The Welfare Minister may order Health Insurance Societies to join a Federation when he deems it necessary for the general welfare of the insured.

The provisions of Articles 23, 23-2, 37, 36 through 39, and 41 shall be applicable to a Health Insurance Federation.

Chapter IV. Insurance Benefits.

Article 43. The following benefits shall be provided for sickness and injury of the insured person:

1. Medical examination;
2. Supply of medicines and other therapeutical materials;
3. Medical treatment, operation, and other therapeutical care;
4. Hospitalization and clinical service;
5. Nursing;
6. Transportation.

Benefits stated in items 4, 5, and 6 of the preceding paragraph shall be granted when considered necessary by the insurer or when prescribed by Ministerial Ordinance.

Article 43-2. An insured person desiring to obtain any benefit described in the preceding Article, paragraph 1, items 1 through 4, will receive such benefits from an insurance doctor 1/ or pharmacist, or person appointed by the insurer according to the insured person's choice.

Article 43-3. Insurance doctors and pharmacists shall be appointed by the prefectural governors from among licensed doctors, dentists, and pharmacists.

An agreement by each doctor, dentist, or pharmacist appointed shall be necessary to effect the appointments stated in the preceding paragraph.

The insurance doctors or pharmacists who are appointed according to paragraph 1 of this Article shall exercise medical care and the granting of medicine in accordance with the requirements of the prefectural governor.

1/ "Insurance doctor" as used throughout this translation means "insurance doctors and insurance dentists"

Insurance doctors or pharmacists may resign their positions when they desire.

When an insurance doctor or pharmacist wishes to resign in accordance with the preceding paragraph he shall submit a statement of his resignation one month in advance.

Article 43-4. Insurance doctors and pharmacists shall exercise kindness and care in dispensing medical care to the insured and to the insured's dependents.

If insurance doctors or pharmacists neglect their obligations in giving medical care, the prefectural governor may cancel their appointments.

Article 43-5. A Central Social Insurance Medical Care Advisory Council and Local Social Insurance Medical Care Advisory Councils shall be organized to guide and supervise insurance doctors and pharmacists for proper social insurance medical care.

The Welfare Minister shall appoint the members of the Central Social Insurance Medical Care Advisory Council and the prefectural governors shall appoint the members of the Local Social Insurance Medical Care Advisory Councils. The membership of each council shall consist of an equal number of representatives from among the representatives of the insurer, insured and employers, physicians and dentists, and the public interest.

The above appointments of persons who are to represent the insured and employers, and physicians and dentists, shall be from among those recommended by the organizations concerned.

Article 43-6. The amount of cost which insurance doctors, pharmacists, or persons 1/ that employ doctors, dentists, or pharmacists, are to charge the insurer for medical care provided, shall equal the amount determined for such medical care.

The medical care claims as submitted to the insurer for medical care provided to the insured shall be calculated by the insurer in accordance with the fee schedule determined by the Welfare Minister.

The Welfare Minister in making fee determinations, according to the provisions of the preceding paragraph, shall consult the views of the Social Insurance Medical Fee Calculating Committee.

1/ Persons, juridical persons, organizations, etc., that extend employment to medical personnel.

Article 43-7. For the purpose of recommending proper medical care fees for Health Insurance, the Social Insurance Medical Fee Calculating Committee shall be established.

The members of the said Committee shall be appointed by the Welfare Minister with an equal number of representatives from among representatives of the insurer, insured and employer, physician and dentist, and public interest.

In the above appointments the persons who are to represent the insured and employers, and the physicians and dentists, shall be from among those recommended by the organizations concerned.

Article 44. When an insurer cannot provide medical care benefits, or if in time of urgency or owing to unavoidable circumstances it is considered necessary to provide medical care for the insured by doctors, dentists, or others who are not insurance doctors or persons designated by the insurer, the cost of medical care may be allowed in place of medical care benefits.

Article 44-2. The amount of cost of medical care that is allowed according to the provisions of the preceding article, shall be decided by the insurer, based upon the amount required for medical care.

In applying the provisions of the preceding paragraph, the amount of cost of medical care shall not exceed the actual cost.

For the calculation of expenses required for medical care as prescribed in paragraph 1 of this article, the provisions of paragraphs 2 and 3 of Article 43-6 shall be applied.

Article 45. When an insured person is not able to work because he is taking medical care, his daily sickness allowance, beginning with the fourth day of his incapacity, shall be equal to 60 per cent of his standard daily remuneration.

Article 46. Sickness allowances payable to insured persons accomodated in hospitals and clinics, if in the event the insured does not have a family to support, shall be equal to 40 per cent of the insured's standard daily remuneration.

Article 47. The time limit during which sickness allowances are payable for the same sickness or injury, or for sickness arising therefrom, shall be six months, beginning with the first day of the incapacity.

For special types of sickness, as designated by the Welfare Minister, the insurer may continuously grant sickness allowance prescribed in the

preceding paragraph for a year and one half after the elapse of the period of the preceding paragraph.

Article 48. Deleted.

Article 49. When an insured person dies, the persons who were supported by him and who perform the funeral and burial services are entitled to a funeral expenses equal to the standard monthly remuneration of the deceased. If, however, the said sum is less than 2,000 Yen, then 2,000 Yen shall be allowed.

When, on the death of an insured person, there is no beneficiary entitled to the funeral expenses, according to the provision of the preceding paragraph, the persons who performed the funeral and burial service will receive a cash payment equal to the funeral expenses or within the limit of the sum previously mentioned.

Article 50. When an insured person has been confined in bed because of giving birth to a child, she shall be paid an amount for confinement equal to 50 per cent of her standard monthly remuneration. If however the amount is less than 1,000 Yen, then 1,000 Yen shall paid.

When an insured person is incapable of work because of confinement she shall be paid an amount calculated as 60 per cent of her standard daily remuneration for a period of 84 days. Such period will begin 42 days before the day she gives birth to the child.

Article 50-2. When an insured person has given birth to a baby and she nurses the same baby, she shall be paid 100 yen per month for six months as a nursing allowance. Payments shall be calculated from the day of the birth of the child and a period of less than one calendar month, at the beginning of the period, shall be calculated as one month.

The nursing allowance specified in the preceding paragraph shall be granted although the insured gives birth to a child within 6 months from the day of her loss of qualification, or although the insured loses her qualification while receiving a nursing allowance.

Article 51. The insurer may admit insured women into maternity hospitals.

The amount of expense which is to be paid to an insured person who is admitted to a maternity hospital, hospital, or clinic shall be equal to one-half of the amount which would be paid in accordance with the provisions of Article 50, paragraph 1.

With respect to maternity allowance which is to be granted to an insured woman who is admitted to a maternity hospital, hospital, or clinic, the provisions of Article 46 shall be applicable.

Article 52. Deleted.

Article 53. Deleted.

Article 54. During the period when a maternity allowance is granted a sickness allowance is not payable.

Article 55. Insured persons who are disqualified as insured persons during the period in which they are receiving benefits for sickness, or maternity may continue to receive such benefits from the same insurer for the duration of the term to which such person would have been entitled to benefits had he or she not been disqualified.

Article 56. When an insured person dies while receiving benefits according to the provision of the preceding article, or a person who previously received benefits according to the provisions of the preceding article dies within three months after the date on which he ceased to receive benefits, or a person previously insured dies within three months after the date of his disqualification, the persons who were supported by the deceased and who perform the funeral services are entitled to receive funeral allowances from the last insurer of the deceased.

The provisions of Article 49 will be applicable with respect to the preceding paragraph when there is no beneficiary to receive the funeral allowance or the amount to be determined.

Article 57. When the confinement of a woman who was an insured person occurs within six months after date of her disqualification as an insured person, allowances associated with childbirth, payable to an insured person, shall be payable to her by her last insurer.

Article 57-2. Regardless of the provisions of the preceding three articles, persons who have insurance rights under the Seamen's Insurance Law shall not be entitled to Health Insurance benefits or allowances.

Article 57-3. Benefits and allowances for medical care for the same disease or injury of an insured, or for a disease resulting therefrom, shall not be paid under the following circumstances:

1. When the insured is to receive an accident annuity or an accident allowance provided by the Welfare Pension Insurance Law.

2. When the insured has not recovered from a disease or injury after receiving medical care for a period of two years.

Article 58. A sickness and injury or maternity allowance shall not be paid to persons who suffer from a disease, injury, confinement, or childbirth during a continuous period when all or a part of their remuneration is receivable. However, if the amount of their remuneration which they can receive is less than that of a sickness and injury or maternity allowance, the difference between the amount of remuneration they can receive and the total amount of the allowance shall be paid.

Article 59. When insured persons, as mentioned in the preceding article, do not receive all or part of their remuneration which they are eligible to receive by contract at the time of sickness and injury or maternity, the total amount of the sickness and injury or maternity allowance, or the difference between the said allowances and remuneration received when the remuneration received is less than that of the said allowance, shall be given to them by the insurer. When an insured person receives a part of the said allowance, in accordance with the provisions of the preceding article, such amount of the allowance shall be omitted from the balance payable to the insured.

The sum paid by the insurer in accordance with the provisions of the preceding paragraph shall be collected from the employer of the insured person.

Article 59-2. When a dependent of an insured person has received medical care from a doctor chosen by the dependent from among insurance doctors, pharmacists, or persons designated by the insurer, the amount for dependents medical care expenses necessary for the medical care shall be paid to the insured.

An amount equal to 50 per cent of the expenses necessary for medical care may be allowed as dependent's medical care expenses, provided that such amount allowed is not more than 50 per cent of the actual amount paid.

When dependents of an insured person have received medical care from an insurance doctor, pharmacist, or person designated by the insurer, within the limit of the fixed sum to be paid to the insured, the insurer may pay the expenses necessary for the medical care expenses to the insurance doctor, pharmacist, or other designated person instead of to the insured.

When the expenses necessary for medical care have been paid to insurance doctors, pharmacists, or persons designated by the insurer or to persons who employ them, in accordance with the provisions of the preceding paragraph, the dependent's medical care expenses within the

limit of the actual amount paid shall be deemed as having been paid to the insured.

The provisions of Articles 43 and 43-2; Article 43-6, paragraphs 2 and 3; and Articles 44, 44-2, 55, and 57-3 shall be applicable to dependents medical care expenses.

Article 59-3. When a dependent of an insured person dies the insured shall be paid funeral expenses of 1,000 yen.

Article 59-4. When the wife of an insured person gives birth to a baby, the insured person shall be granted 500 yen as the expenses of childbirth.

When the preceding paragraph is applicable, a nursing allowance shall be granted to the insured, providing the mother nurses the child.

When a nursing allowance as specified in the preceding paragraph is granted the provisions of Article 50-2, paragraph 1, shall be applicable.

Article 59-5. Notwithstanding the provisions of Article 59-2, paragraph 1, an insurer may entrust the matter of the payment of dependent's treatment expenses to a city, town, or village; to a National Health Insurance Association; or to a corporate juridical person, providing such entities undertake the functions of administering National Health Insurance (hereinafter referred to as "those who exercise National Health Insurance"). In such cases the insurer shall pay the necessary expenses to those who exercise National Health Insurance.

With respect to the payment of dependent's medical care expenses to the insured by those who exercise National Health Insurance, such agents are given authority to act for the insurer in accordance with the provisions of the preceding paragraph, and the provisions of Article 59-2, paragraph 3, shall be applicable.

Article 60. Insured persons and persons previously insured will not be granted benefits when cause for benefits is brought about intentionally or is attributable to intentional criminal acts of the insured.

Article 61. Full or partial benefits may not be granted when the cause for benefits arises through an insured's fighting, intoxication, or extreme profligacy.

Article 62. Insured persons and those who were previously insured shall not be granted benefits for sickness and injury or maternity when subject to any one of the following conditions:

1. When outside Japanese territory.

2. When sent to a house of correction or to such other institution.

3. When imprisoned or detained in jail, police cell, or work-house.

When in accordance with the regulations of other laws, medical benefits or medical allowances are granted to persons at a cost of the Treasury or public corporation, medical benefits under this Law shall cease to be granted.

The provisions of Article 46 and Article 51, paragraph 2, are applicable to persons subject to the provisions of the preceding paragraph.

When any of the conditions in paragraph 1 of this article are applicable to insured persons, or to those previously insured, the insurer is not precluded from granting the dependents the benefits mentioned in the latter part of Article 1, paragraph 1.

Article 63. A part of the benefits granted may be withheld when medical orders are disobeyed without good reason.

Article 64. When an insured person has received or tried to obtain insurance benefits by fraud or other dishonest method, a decision can be made by the insurer to deny the payment of all or part of the sickness and injury allowance or maternity allowance payable for a period of six months; however, this decision cannot be made after a lapse of one year.

Article 65. When deemed necessary the insurer may have persons receiving benefits undergo a medical examination.

The total or part of the benefits may be withheld from those who without good reason refuse to undergo a medical examination.

Article 66. Medical care expenses, sickness and injury allowances, maternity allowances, funeral expenses, delivery expenses, dependent's medical care expenses, dependent's funeral expenses, spouse delivery expense, and nursing allowances shall be paid on all occasions when beneficiaries are eligible, and the funeral expenses, mentioned in Article 49, paragraph 2, or in Article 56, paragraph 2, shall also be subject to this rule.

Notwithstanding the provisions of the preceding paragraph, a sickness and injury allowance, maternity allowance, and nursing allowance may be paid monthly on a fixed date determined by the insurer.

Article 67. When an insurer has granted benefits in a case where the cause of the benefit condition was attributable to a third party, the insurer acquires the right to demand the damages which the insured person or those previously insured possess against the third party, according to the limit of the benefit sum.

Article 68. The right to receive benefits may not be transferred nor seized.

Article 69. Taxes and other public imposts shall not be imposed on the cash and other articles received as benefits.

Article 69-2. The provisions of Articles 60; 62, paragraph 1 and 2; 65; and 67 are applicable to dependents.

Article 69-3. When the insurer is a Health Insurance Society other benefits besides those stipulated in this Law may be granted according to the provisions of the Articles of the Society.

Chapter V. Expense Charges.

Article 70. The National Treasury shall pay the necessary administrative expenses for Health Insurance and the amount shall be fixed by the National annual budget.

Article 70-2. The administrative expenses of a Health Insurance Society which are to be paid by government subsidy shall be computed by the Welfare Minister, calculated on the basis of the number of insured persons in the Society.

The government subsidy mentioned in the preceding paragraph may be roughly estimated and allocated to the Societies.

Article 71. Contributions are charged to meet the expenses of Health Insurance.

The monthly contribution of the insured shall be calculated as the product of the insured's standard monthly remuneration and contribution rate.

Regardless of the provision of the preceding paragraph, contributions will not be calculated on a continuously insured person 1/ for the month in which the person was disqualified.

1/ A person who was insured during the month preceding the month in which disqualification occurred. (A person who establishes qualification during the month of disqualification will be subject to contributions).

Article 71-2. The contributions of an insured person according to the provisions of Article 20 shall be calculated as of the month he is entitled to insurance.

With respect to persons subject to the preceding paragraph, the contributions for each succeeding month shall be calculated according to the provisions of the preceding article.

Article 71-3. When an insured person who was insured during the preceding month falls within the purview of Article 62, paragraph 1, items 1, 2, or 3, he shall not be charged contributions during the month in which he becomes subject and during the following complete months he remains subject to Article 62, paragraph 1, items 1, 2, or 3, and his contributions will begin with the month in which he ceases to be subject to Article 62, paragraph 1, items 1, 2, or 3; however, when a person falls within the purview of Article 62, paragraph 1, items 1, 2, or 3, in the same month in which he qualifies without being insured in the preceding month, or when an insured person becomes and ceases to be subject to Article 62, paragraph 1, items 1, 2, or 3, during the same month, such persons shall be subject to contributions for the month in which they became subject to Article 62, paragraph 1, items 1, 2, or 3.

Article 71-4. The contribution rate of Government-managed Health Insurance shall be 4 percent, except as follows:

When there is any shortage in the necessary funds for the payment of the expenses of insurance benefits or the expenses of insurance facilities, or in case there is a surplus, under the existing contribution rate, the Welfare Minister may have the contribution rate changed within the limits of 3.6 per cent to 4.4 per cent, based upon the opinion of the Health Insurance Advisory Council.

The contribution rate of Society-managed Health Insurance shall be decided within the limit of 3 per cent to 8 per cent, according to regulations prescribed by Cabinet Order.

The decision for and the revision of the contribution rate prescribed in the preceding paragraph must be approved by the Welfare Minister to be enforceable.

Article 72. Contribution charges are to be shared in equal parts by insured persons and the employers who employ the insured; however, persons insured according to the provisions of Article 20 must bear the entire sum.

Article 73. Deleted.

Article 74. Deleted.

Article 75. Regardless of the provisions of Article 72 a Health Insurance Society may, in its Articles of the Society, increase the rate of contributions to be borne by the employers.

Article 75-2. The amount of contributions borne per month by insured persons of a Health Insurance Society shall not exceed 2.5 per cent of their monthly standard remuneration, and in case one-half of the total employer and employee contributions charged by the insurer exceeds 2.5 per cent of the insured's remuneration the employer shall pay the excess.

Article 76. Deleted.

Article 77. Employers are responsible for the payment to the insurer of their own contributions and the contributions to be borne by their insured employees; however, such provision does not apply to the contributions of persons insured according to the provisions of Article 20.

Regardless of the provisions of the preceding paragraph an employer, in case the insured ceases to be an employee, may at time of settlement of insured's remuneration, deduct the contributions to be borne by the insured for the preceding and current months.

The employer, when he deducts contributions, as provided in the preceding two paragraphs, shall make a statement of the deduction and shall notify the insured as to the amount deducted.

Article 79. The contributions to be paid to an insurer for a specific month shall be paid by the end of the following month.

When an insurer discovers that contributions have been charged or paid in excess of the amount due because of an overcharge by the insurer or because of an overpayment by the contributor, the insurer shall credit within six months the amount of the overcharge or overpayment to contributions becoming due from such contributor within the said six months.

According to the preceding provision, if it is regarded that the date of payment was advanced and the notice of payment has been made or paid, the insurer shall notify the contributor concerned.

Article 79-2. When a contributor who is to pay contributions becomes subject to any of the following conditions or circumstances, the contributions may be collected before the due date.

1. When an action pertaining to deliquency for national tax, local tax, or other public levies has been instituted.

2. When the office where the insured has been employed is being abolished.

3. When compulsory seizure is effected.

4. When adjudged insolvent.

5. When a closing auction is to be held.

6. When a juridical person is to dissolve a business where the insured has been employed.

Chapter VI. Appeals and Lawsuits.

Article 80. Any person who dissatisfied with the determination of the insurance benefit may appeal to the Insurance Referee, and if the person mentioned above is dissatisfied with the decision of the Referee, he may appeal the case to the Health Insurance Appeals Board and if dissatisfied with the decision of said Board, he may bring a suit to the court.

As to the interruption of the statute of prescription by the appeal prescribed in the preceding paragraph, it shall be regarded the same as a request for a law-suit.

Article 80-2. Deleted.

Article 81. Any person who is dissatisfied with the amount of contributions or other assessments levied under this Law, with the action taken in collecting such amounts, or with the procedure as provided in Article 11-2 of this Law, may appeal to the Health Insurance Appeals Board.

Article 81-2. The Welfare Minister shall appoint an Insurance Referee in each prefecture and shall choose them from among local officials who are secretaries 2nd class.

Article 82. The Health Insurance Appeals Board shall be established in the Welfare Ministry.

Article 83. The Health Insurance Appeals Board shall consist of 3 persons representing the insured persons, 3 persons representing the

employers, and 3 persons representing the public interest and each member shall be appointed by the Welfare Minister.

Article 83-2. The term of office of members of the Health Insurance Appeals Board shall be 3 years, and one third of the members shall be appointed annually.

A person appointed to fill a Board vacancy shall complete the term of office of his predecessor.

Article 83-3. There shall be a chairman of the Health Insurance Appeals Board elected by the members from among those members who represent the public interest.

In case of the chairman's absence, an acting chariman shall be elected in the manner prescribed in the preceding paragraph.

Article 83-4. The Health Insurance Appeals Board shall not commence proceedings or make a decision without the presence of at least one member representing the insured persons, one member representing the employers, and one member representing the public interest.

Article 83-5. A decision of the Health Insurance Appeals Board on any case shall be made by a majority of those present. In case of a tie the chairman shall make the decision.

Article 83-6. Any person who is dissatisfied with a decision with regard to payment of benefits and wishes to appeal shall do so to the Insurance Referee who is competent of the jurisdiction of the prefectual governor who made the decision or of the area where the office of the Health Insurance Society which made the decision exists.

The appeal mentioned above may be made through the prefectural governor who made the decision or the Health Insurance Society which made the decision with regard to the payment of benefits or through the prefectural governor or the Insurance Referee who are competent of the residence of the claimant.

When it is found that the appeal, in accordance with the preceding paragraph, belongs to the district of a different jurisdictional area, the Insurance Referee shall transfer the appeal to the proper district and shall notify the applicant to that effect.

Article 83-7. An appeal to an Insurance Referee or to the Health Insurance Appeals Board may be made either in writing or orally.

Article 83-8. The Insurance Referee and the Health Insurance Appeals Board shall hold a hearing promptly after receiving an appeal. In case,

however, it is difficult for the claimant to attend the hearing the Insurance Referee and the Health Insurance Appeals Board may hold a hearing on the basis of written statements in lieu of said procedure.

Article 83-9. When the Insurance Referee or the Health Insurance Appeals Board deems it necessary, they may require the person responsible for the award of insurance benefits, the employer, the claimant, or other interested parties or witnesses to submit evidence or attend the hearing for questioning and may authorize a doctor to make medical examinations and report his findings.

The prefectural governor, with respect to a hearing held by the Insurance Referee, and the Welfare Minister, with respect to a hearing held by the Health Insurance Appeals Board, shall grant travelling expenses, allowance and hotel charge, as prescribed by Cabinet Order, to persons who attend the hearing at the request of the Insurance Referee or the Health Insurance Appeals Board, according to the provisions of the preceding paragraph.

Article 83-10. The person responsible for the award of insurance benefits, the employer, the claimant, and other interested parties and witnesses may express their opinions or submit documentary evidence to the Insurance Referee or the Health Insurance Appeals Board.

In case the claimant considers it necessary, he may bring an advisor to attend the hearing with him.

In case any interested party cannot attend the hearing he may authorize a representative to attend in his place.

Article 83-11. In case a certain limited portion of the case has been settled, the Insurance Referee or the Health Insurance Appeals Board may make the decision respecting that part first.

Article 83-12. The decisions of the Insurance Referee and the Health Insurance Appeals Board shall be in written form with explanations.

Article 83-13. If the applicant dies before conclusion of the case the right of appeal shall be transferred to his successor.

Article 84. Deleted.

Article 84-2. For the purpose of a law-suit regarding a decision made by a Health Insurance Society with respect to the matters referred to in Articles 80 and 81, the said Society shall be regarded as a government office.

Article 85. No insurance Referee, member of the Health Insurance Appeals Board, or person who is working or has worked for the Health Insurance Appeals Board shall disclose a secret which he learned while performing his duty.

Article 86. An appeal shall be made or a law-suit instituted within 60 days from the date of receiving a written decision, provided, that with respect to an appeal this time limit may be extended for good cause as determined by the Insurance Referee or the Health Insurance Appeals Board, as appropriate.

With respect to the institution of a law-suit as prescribed in the preceding paragraph, Article 158, paragraph 2, and Article 159 of the Code of Civil Procedures shall be applicable.

Article 86-2. Matters of an administrative nature concerning the Insurance Referee and the Health Insurance appeals Board may be provided for by Cabinet Order.

Chapter VII. Penal Regulations.

Article 87. The competent official, government official, or persons who were formerly in that capacity, on revealing without reason, the occupational and private secrets of doctors or dentists acquired through the inspection of medical care records, in accordance with the provisions of Article 9-2, shall be subject to a sentence of not more than 6 months of penal servitude or a fine of not more than 5,000 Yen.

Other officials or those formerly in office, on revealing, without reason, secrets mentioned in the preceding paragraph, acquired through the execution of official duties, shall be subject to the same prison sentence and fine as stipulated in the preceding paragraph.

Doctors, dentists, or those employing them that hinder, refuse, or evade an inspection by authorized officials, according to the provisions of Article 9-2, shall be subject to a fine of not more than 5,000 Yen.

Any person subject to the provisions of Article 9 who refuses to answer to the authorized official in accordance with the provisions of Article 9, or on giving false answer or on hindering, refusing, or evading the official inspection without sufficient reason, shall be subject to a fine of not more than 10,000 Yen for an employer and 5,000 Yen for persons receiving benefits or other relative persons except employers.

Article 88. Employers refusing to present documents or giving false reports, without reason, or disobeying the requests of the insurer, made according to the provisions of Article 8, shall be subject to a fine of not more than 10,000 Yen.

Article 88-2. Persons who are entitled to receive benefits who, without reason, violate the provisions of an order issued in conformity with the provisions of Article 8-2, neglect to make notification or report, or make false notification or report, or neglect to present documents, or make a false record in documents, shall be subject to a fine of not more than 5,000 Yen.

Articles 88-3. Any person refusing to give a report, without reasons, or giving a false report, or refusing to attend a hearing, or refusing to undergo a medical examination, in case such is demanded by the Insurance Referee in accordance with the provisions of Article 83-9, paragraph 1, shall be subject to a fine of not more than 5,000 Yen.

Article 89. When an employer who is charged with the establishment of a Health Insurance Society fails, without reason, to apply for approval of the Society by the date set by the Welfare Minister, he shall be subject to a fine of not more than twice the amount of contributions to be borne during the period of such delay in making application.

Article 90. In case a Health Insurance Society or a Health Insurance Federation violates the order prescribed in Article 37 (including the cases when Article 42-2, paragraph 5, is applicable), refuses, or hinders the action of the Welfare Minister, the officials of the Society or Federation shall be subject to a fine of not more than 5,000 Yen.

Article 91. In case any representative of a juridical person, or any deputy or employee of, or any other person working for a juridical person or an individual, commits offenses in relation to the business of the said juridical person or individual, as mentioned in Article 87, paragraph 3 or paragraph 4, or in Articles 88 and 88-2, the fine provided for in the said article shall be imposed upon the juridical person or the individual concerned, in addition to the offenders being liable to punishment as provided for.

Supplementary Provisions.

1. This Law shall come into force from 1 August 1948; however, the amended provisions of Article 70 and Article 70-2 shall come into effect from the fiscal year 1948.

2. As to the person who is qualified as insured as of the time of operation of the present Law and date of enforcement of the present Law and is designated to the No. 17 grade under the classified standard remuneration prescribed in Article 3 of the Enforcement Ordinance (1926 Cabinet Order No. 243) he shall be regarded as qualified as an insured on the date of the operation of the present Law and as a result he shall be subject to Article 3, paragraph 3, of the Health Insurance Law.

3. The existing Insurance Referees and Social Insurance Appeals Board and its officials at the time of enforcement of this Law shall become the corresponding organ and officials provided by the Law and with the same legal personality.

INDEX BY ARTICLE OF THE HEALTH INSURANCE LAW

CABINET ORDER

English Translation of the Japanese

ENFORCEMENT REGULATIONS OF THE HEALTH INSURANCE LAW

(As established by Cabinet Order No 243, June 1926, and amended by Cabinet orders in 1927, 1929, 1934, 1938, 1940, 1941, 1942, 1944, 1945, 1946, June 1947, and August 1948).

25 February 1949

Social Security Division

PHW GHQ SCAP

Incl 2

ENFORCEMENT REGULATIONS OF THE HEALTH INSURANCE LAW

(As established by Cabinet Order No. 243, June 1926 and amended by Cabinet Order in August 1948).

Chapter I. General Rules. Deleted 1/

Articles 1 through 8. Deleted.

Chapter II. The Insured Person. Deleted.

Articles 9 through 10-2. Deleted.

Chapter III. Health Insurance Societies and Health Insurance Federations.

Section 1. Formation of a Society.

Article 11. When the employers who desire to form a Health Insurance Society seek to obtain the consent of those insured, as provided in Article 29 of the Health Insurance Law, the employers must inform the insured employees subject to Article 29 of the Health Insurance Law and must also inform the employees to be insured as provided by Article 30 of the Health Insurance Law, of the following matters:

1. The number of and the type of employment of those who are to become member of the Society.

2. The proposed organization of the Society.

3. The proposed contribution rates.

4. The proposed insurance benefits.

5. The proposed plan of operations.

Article 12. In the Society's articles the following matters shall be provided:

1. The title or name of the Society.

2. The location of the Society's office.

3. The name and location of each working place where the Society is to be in effect.

1/ Chapters I, II, IV, and V were incorporated in their entirety in the basic Law, in July 1948.

4. The method of publication to be used by the Society.

5. Other important matters concerning the Society.

Article 13. The Society shall use the phrase "Health Insurance Society" in its title or name.

An organization that is not a Health Insurance Society shall not use the phrase "Health Insurance Society" in its title or name.

Article 14. The employer and employee contribution rates to be applied and an estimate of the income and expense of the Society for the first year of its operation shall be made by the employers seeking to form the Society and shall be submitted to the Welfare Minister for approval.

Article 15. When the Welfare Minister approves the formation of a Society he shall publish the following information:

1. The title or name of the Society.

2. The location of the office of the Society.

3. The name and location of the working place where the Society shall be in effect.

4. The date of approval.

When the competent authority 1/ approves a change in a Society's articles with respect to items 1 or 2 mentioned above, he shall make such change public.

Article 16. When the approval for forming a Society is obtained the employers of the Society shall publish without delay the articles of the Society.

Article 17. When the approval for forming a Society is obtained the employers shall convene the council of the Society without delay and shall report the status of the formation of the Society, the contribution rates to be used, the estimate of the income and expense for the first year of operation, and other important matters.

Article 18. After the Society is formed and until the directors of the Society take over their official duties the employers shall exercise the duties of the directors.

Section 2. The Council of the Society.

1/ See Article 73.

Article 19. A Health Insurance Society shall form a Society Council.

The Society Council shall consist of a chairman and councillors.

Article 20. A Society council shall have a fixed even number of councillors. One-half of the councillors shall be appointed by the employers from the employers, their deputies, or employees, and one-half shall be elected by a mutual vote of the Society members from the insured members.

Article 21. When councillors assume their duties, or when they resign or die, the event shall be made public without delay.

Article 22. Deleted.

Article 23. When a Society member questions the validity of the election of councillors or the vote of councillors who participated in the election he shall be permitted to file a protest with the directors of the Society within 7 days from the date of the publication specified in Article 21.

When a protest in files the directors shall submit it within 20 days to the council for a decision and when such decision is made it shall be published without delay.

When a protesting member is not satisfied with the decision made b the council he may appeal to the competent authority within 30 days fr the day of the council's decision. In such case the Health Insurance Society shall be regarded as an authorized government office 1/ provide by the Appeal Law.

Councillors shall not lose their right to attend the council meetings and to participate in council discussions while the decision mentioned in the second paragraph of this article is being made or while the decision on the appeal as mentioned in the preceding paragraph is being made.

Article 24. In addition to the provisions of these enforcement regulations, matters of the Society concerning the fixed number, qualification, term of office, and election of councillors shall be governed by the provisions of the articles prescribed by the Society.

Article 25. Matters of the Society upon which a Society council must make decisions shall be as follows:

1. The preparation of estimates of income and expense.

1/ The Welfare Minister or the prefectural governor.

2. The preparation of reports on operations and the settlement of accounts.

3. The assumption of obligations besides those provided in the estimates of income and expense, and the giving up of Society rights.

4. The methods to be employed in controlling reserve funds.

5. The disposal of a reserve fund or other important property.

6. The negotiation of a loan for the Society.

7. A change in the articles of the Society.

8. The contribution rates to be used.

9. The institution and settlement of appeals and law-suits.

10. Other important matters of the Society.

Article 26. The Society council shall be able to inspect documents concerning the business of the Society, demand reports from its directors, examine the management of the business and the execution of decisions, and examine receipts and expenses.

The Society council shall be able to appoint committees composed of councillors and require them to handle council matters.

Article 27. The Society council shall be convened by the directors.

When more than one-third of the fixed number of councillors request the convening of the council for the purpose of handling matters which are subject to council action, the directors shall convene the council within seven days.

The convening of the council shall be made at least three days before the opening day of sessions except when matters are urgent and demand that the sessions start immediately.

The Society shall be able to prescribe further rules with respect to the period mentioned for convening the council.

When the council is in session and urgent matters arise the directors shall be able to submit such matters to the council immediately.

The sessions of the council shall be opened and closed by the directors.

Article 28. The chairman of the concil shall be appointed by the directors and he shall preside over the council meetings and maintain order in the council room.

Article 29. When less than half of the fixed number of councillors are present, the council sessions shall not be opened; however, when the number is less than one-half because of the exclusions provided in Article 32 this rule shall not apply.

Article 30. The decisions of the Society's council shall be made by a majority vote of the councillors present, and in case of a tie vote, the decision shall be made by the chairman.

Article 31. Any changes made in the articles of a Society must be approved by more than three-fourths of the councillors present.

Article 32. The chairman and councillors shall not be permitted to participate in proceedings of the council that concern their own personal affairs; however, when such persons obtain the consent of the council they shall be able to participate.

Article 33. Each councillor shall attend the council sessions and vote. However, when a councillor is not able to attend the council because of illness or unavoidable circumstances he shall be able to vote by proxy through an entrusted councillor as provided in the articles of the Society. In such event the absent councillor shall be regarded as having been present at the council.

Article 34. Members of the Society shall be able to hear council sessions except when a special session, as provided in the Society's articles, precludes the members' attendance.

Article 35. A councillor shall be able to receive from the Society his travelling fees required to carry out his duties.

When a councillor who is insured is denied emolument from his customary employment because of his service as a councillor, he shall be able to obtain the said compensation from the Society.

The travelling fees mentioned in the first paragraph and the value and method of payment of the above mentioned compensation shall depend on what the articles of the Society provide.

Section 3. Officials of a Society.

Article 36. A Society shall have directors.

The fixed number of directors shall be even. One-half the number shall be elected by a mutual vote of the councillors who were appointed

by the employers, and one-half shall be elected by a mutual vote of the councillors who were elected by the insured members.

One of the directors shall be the chief director and he shall be elected by the directors who were elected from the councillors appointed by the employers.

Article 37. The chief director shall represent the Society. When the chief director is not available because of unusual circumstances another director shall take his place in accordance with the articles of the Society.

Article 38. The affairs of the Society shall be decided by a majority vote of the directors, except in a case covered by the articles of the Society. In case of a tie vote, the decision shall be made by the chief director.

Article 39. When a Society council fails to organize or form 1/, does not decide the matters it should decide, or it is very difficult to convene, the directors of the Society shall be empowered under the direction of the competent authority to dispose of the matters which the council should decide.

Article 40. The directors of a Society shall be able to decide arbitrarily the matters of the Society that are urgent and demand immediate attention and which arise when there is not time to convene the council of the Society or when the council fails to form 2/, or if the matter to be decided is insignificant.

Article 41. When directors dispose of matters in agreement with the provisions of the preceding two articles, they shall report the action to the council at the next session of the Society's council.

Article 41-2. When a change of articles of the Society is approved the directors shall without delay make the change public.

Article 42. The directors shall provide the office of the Society with articles, an inventory of property, reports of business operations, a ledger of the Society's members, and records of the council.

When members of the Society request an inspection of the above mentioned documents, the directors shall not be able to refuse the inspection without good cause.

Article 43. The provisions of Articles 21, 24, and 35, applying to councillors shall with equal force be applicable to the directors and chief director of a Society.

1/ and 2/ Applicable after the initial formation of the council and the election of the directors by the councillors.

Section 4. Financial Affairs of a Society.

Article 44. The fiscal year of a Society shall be the same as that of the Government.

Article 45. A Society shall make an estimate of income and expense each fiscal year and shall obtain the approval of the estimate by the competent authority. When an estimate is corrected or changed, approval of such correction or change must be obtained from competent authority.

The amount of money specified in each major section of an estimate shall not be diverted to another section.

The amount of money specified in each article of a section of an estimate may be diverted to another article of the same section by decision of the Society council.

Article 46. A Society shall be able to negotiate long term expenditures through decision of its council.

Article 47. A Society shall provide an emergency fund to cover expenditures in excess of estimates.

The use of the emergency fund shall be limited by the articles of the Society.

Article 48. A Society shall receive its revenue until May 31 of the next fiscal year and pay its expenditures until April 15 of the next fiscal year before closing its revenue and expenditure accounts for a fiscal year.

Article 49. A Society that desires to change its contribution rates must obtain the approval of the competent authority before making such change.

Article 50. A Society shall accumulate, as a reserve fund, money which corresponds to 5 per cent of the average annual sum (in case the surplus for the year does not reach 5 per cent, then the total surplus for the year) of the past three years cost required to grant benefits (in case the past years are less than three, then the total of such past years).

The reserve fund within the scope mentioned above, shall not be used unless there is a deficiency in the funds required for insurance benefits.

Article 51. Deleted.

Article 52. The methods to be used in controlling the reserve fund and other properties shall be prescribed in the articles of the Society.

Article 53. In the event the Society runs short of cash money for expenses, it shall be able to borrow temporarily the cash belonging to the reserve fund or obtain a temporary loan from others.

The money received according to the preceding provision as a temporary loan shall be repaid to the reserve fund or other creditor within the same fiscal year.

Article 54. When a Society obtains a long term loan, the method of application, the fixed interest rates, and the method of redemption shall be decided and approved by competent authority, and any change in the said matters shall be decided and approved by competent authority.

Article 55. When the Society proposes a disposition of its important properties it shall obtain the approval for such action from the competent authority.

Section 5. Division, Combination, and Dissolution of a Society.

Article 56. The combination or division of a Society shall require the consent of a majority of three-fourths of the councillors and the approval of the Welfare Minister.

When any change in the articles of a Society is required, such shall be made in accordance with the provisions of the preceding paragraph.

Article 57. A division of a Society shall not be made of a part of a working place when such part is within the working place where the Society is in force.

Article 58. When a division of a Society is to be made the number of insured members of the Society which is to continue to exist after the division or the number of members of the Society which comes into existence because of the division, shall not be less than three hundred.

Article 59. The articles, contribution rates, and the estimates of income and expense for the first fiscal year of the Society which comes into existence because of a combination shall be settled by the councillors elected by each Society and shall require the approval of the Welfare Minister.

Article 60. The articles, contribution rates, and the estimates of income and expense for the first fiscal year of the Society which comes into existence because of a division shall be settled by the employers who are members of the Society and shall require the approval of the Welfare Minister.

Article 61. A Society which continues to exist after a combination, or a Society which comes into existence because of a combination, shall take over the assets and liabilities of the Society which discontinues becauses of the combination.

A Society which is formed by a division or which remains after a division shall take over or retain its respective part of the assets and liabilities of the Society in which the division was made.

The limits of the assets and liabilities which shall be taken over by reasons of the preceding provision shall be decided concurrently with the decision of the division and shall require the approval of the Welfare Minister.

Article 62. When the Welfare Minister approves the combination or division of a Society, he shall make public the following matters concerning the Society which comes into existence or discontinues because of the combination or the division and the Society which continues to exist after the combination or division.

1. The title or name of the Society.

2. The locality of the office of the Society.

3. The name and location of the place where the Society is established.

4. The date of approval.

Article 63. The provisions of Articles 16 through 18 shall be applied mutatis mutandis to the Society which comes into existence through a combination or division.

When the directors of a Society which is combined or divided are members of the Society which came into existence because of the combination or division, they shall exercise the duties of the employers as prescribed in the preceding paragraph.

Article 64. The dissolution of a Society shall be decided by the council of the Society and shall require the consent of three-fourths of the fixed number of councillors and the approval of the Welfare Minister.

Article 65. Although a Society may have no insured members it will not be dissolved if the absence of insured members is temporary.

Article 66. When a Society is dissolved the Welfare Minister shall make public the dissolution according to the example stated in Article 62.

Article 67. When the number of working places of a Society is increased or decreased the consent of the employers who are to be included or eliminated and the consent of half or more of the insured or insurable employees shall be required.

When the working places which are to be included or eliminated are two or more in number, the consent of the insured and insurable above prescribed shall be required for each working place.

The insured prescribed in the preceding two paragraphs shall be those to be insured in case the application for the approval of the change of articles concerning the including of the working places is made concurrently with the application for the approval prescribed in Article 14, paragraph 1, of the Health Insurance Law.

Article 68. The provisions of Article 57 shall be applied with necessary modifications concurrently with the preceding article.

Article 69. When a working place is to be eliminated, the number of insured members remaining in the Society shall not be less than three hundred.

Article 70. When a Society is subject to receive the consent prescribed in Article 67, the persons who are to receive or lose membership in the Society because of the inclusion or the elimination of a working place in which they are employed shall be advised as follows: those to receive membership shall be notified of the matters stated in each item of Article 11, and those to lose membership shall be notified of the reasons for the elimination of their working place.

Section 6. Supervision of the Society.

Article 71. Competent authorities shall be able to order the dissolution of a Society's council.

When a Society's council dissolves an election of new councillors shall be made within one month.

Article 72. Those persons who are released from their offices under the provisions of Article 39 of the Health Insurance Law shall not be able to be officials of a Society for two years.

Article 73. The "competent authority" as prescribed in Article 15, paragraph 2; Article 23, paragraph 3; Article 39; Article 45, paragraph 1; Articles 49, 54, and 55; and Article 71, paragraph 1, shall be the Welfare Minister in case of the approval concerning the combination or division of a Society or in case the Society covers two or more prefectures; and

in other cases it shall be the prefectural governor who has authority over the locality where the chief office of the Society is located.

Section 7. Federation of Health Insurance Societies.

Article 73-2. In the articles of a Federation of Health Insurance Societies (hereinafter referred to as "Federation") the following matters shall be stated:

1. The purpose and plan of the Federation.

2. The title or name of the Federation.

3. The location of the office of the Federation.

4. Matters concerning joining or withdrawing from the Federation.

5. Matters concerning assets and liabilities.

6. The method of notification to be employed.

7. Other important matters concerning the Federation.

Article 73-3. A Federation shall use the phrase "Federation of Health Insurance Societies" in its title or name.

An organization which is not a Federation of Health Insurance Societies shall not use the phrase "Federation of Health Insurance Societies" in its title or name.

Article 73-4. An estimate of the income and expense for the first fiscal year of the Federation shall be decided by the Societies which are to establish the Federation and it shall be approved by the Welfare Minister.

Application for approval as provided in the preceding paragraph shall be made concurrently with the application for approval of formation of the Federation.

Article 73-5. The cost required to establish a Federation shall be borne by the Federation.

Article 73-6. A Federation shall have general meetings and a president, vice-president, and directors.

General meetings shall be held by a chairman 1/ and general meeting members.

The general meeting members shall be elected by a mutual vote of the chief directors of the Societies forming the Federation. However, members of a general meeting who make decisions concerning the dissolution of the Federation according to the provisions of Article 64, applied with necessary modifications, or by the provisions of Article 73-9, shall be appointed by the chief directors of the Societies forming the Federation.

The president of the Federation shall be elected by a mutual vote of the directors of the Federation.

Besides those matters which are provided in these regulations, the matters pertaining to the organization and powers of the general meeting; the fixed number, qualification, term and election of members of the meeting; the fixed number, qualification, term, election, and powers of the president, vice-president, and directors of the Federation shall be decided by articles of the Federation.

Article 73-7. A Federation shall be regarded as existent within the scope of the object of liquidation, even if it dissolves.

Article 73-8. When a Federation dissolves, the Federation directors shall become the liquidators.

In the event there are no directors available to serve as liquidators, according to the preceding provision, the Welfare Minister shall appoint liquidators. When liquidators fail or cannot perform their duties, the Welfare Minister shall appoint liquidators.

Liquidators shall represent the Federation and have powers to exercise every action required to effect liquidation.

With respect to the method employed in liquidation and disposal of Federation properties, the liquidators shall obtain the approval of the Welfare Minister.

When the Welfare Minister considers it necessary he shall be able to order a change in the method of liquidation and disposal of properties, or he may release the liquidators from their offices.

Action 73-9. The provisions of Articles 15; 16; 21; 25 through 33; 37 through 42; 44 through 48; 54; 55; 64; 71, paragraph 1; and 72 shall be applied with necessary modifications to Federations; however, the employers referred to in Article 16 shall be changed to directors, and

1/ No provision is made for the election or appointment of the Chairman other than the general provision for handling "other matters" as stipulated in Article 73-6, paragraph 5.

the competent authorities mentioned in Articles 39; 45, paragraph 1; 54; 55; and 71, paragraph 1, shall be changed to Welfare Minister.

Article 73-10. The provisions of Article 21 shall be applied with necessary modifications to the president, vice-president, and directors of a Federation.

Article 73-11. In addition to the matters provided in these regulations, other necessary matters concerning the Federation shall be decided by Ministerial Ordinance.

Chapter IV. Insurance Benefits. Deleted. 1/

Articles 74 through 89. Deleted.

Chapter V. Liability. Deleted. 1/

Articles 90 through 101-2. Deleted.

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1/ Chapters IV and V were incorporated in their entirety in the basic Law in July 1948.

GUIDE FOR A REVIEW OF A SOCIETY
ADMINISTERING HEALTH INSURANCE (Kenko Hoken)

1. Identity of Society -
   a) Name:_____. b) Location:_____
   c) Date of Formation:_____. d) Predecessor:_____
   e) Federation name, if member:_____

2. Coverage Data -
   a) Number of insured members: Male_____, Female_____
      Total_____
   b) Number of dependents: Male_____, Female_____
      Total_____
   c) Number of employers:_____
   d) Number of establishments: _____
   e) Types of industry or industries covered: _____

3. Administrative Bodies -
   a) Councillors: Number in Office
      Representing employer:_____
      Representing employees:_____
   b) Directors: Number in Office
      Representing employer:_____
      Representing employees:_____

4. Services and Allowances -
   a) Indicate services provided: medical examination___, drugs___, appliances___, medical treatment ___, surgical operation ___, medical attendance___, hospitalization___, clinical service___, dental service ___, nursing service___, transportation___, other (specify):_____
   b) Indicate allowances provided: maternity___, nursing___, delivery___, funeral___, medical treatment___, sickness and injury___, family treatment expense___, other (specify):_____

5. Facilities, Personnel, and Service Data -
   a) Enter the number of facilities available according to type: hospitals_____, clinics_____, other (specify):_____
   b) Enter hospital capacity for medical care:
      in-patients_____, out-patients_____
   c) What dental facilities are provided?_____
   d) What facilities are provided for TB patients?_____
   e) Enter number of full-time staff personnel: doctors_____, nurses_____, dentists_____, pharmacists _____, clerks_____, other_____, Total_____.
   f) What percent of the service is conducted by full-time doctors?
      _____%

Incl. No. 3

g) What percent of the service is conducted by insurance doctors? _____%

h) What percent of the service during the past fiscal year was given to the insured members?_____%, to their dependents?____%

6. Financial Affairs and Operations -

a) Contributions: enter, employer rate _____%, employee rate _____%, and average amount per employee for the last fiscal year _____¥,

b) Enter the total income received during preceding fiscal year _____¥, and the per cent of such total received from employer constibutions _____%, employee contributions _____%, government subsidy _____%, other sources____%

c) Enter the total expense for the preceding fiscal year_____¥, and the per cent of such total expended for medical benefit _____%, temporary disability benefit _____%, burial expense_____%, delivery expense_____%, maternity care _____%, child birth allowance_____%, family medical expense_____%, family burial expense_____%, wifes delivery expense_____%, other benefits_____%, walfare service _____%, administration_____%, other _____%.

d) What percent of the benefits granted during the preceding fiscal year were paid in cash? _____%.

e) Enter the amount of assets _____¥, liabilities_____¥, and reserve account _____¥ of the society at tne end of preceding fiscal year.

f) Give last date of periodic audit of society:_____

g) Who conducted the audit?_____

h) Have monthly reports been submitted promptly?_____

7. Payment of Medical Services -

a) What is the amount allowed per medical fee point?_____¥

b) Does the society utilize the facilities of the Medical Fee Payment Fund in the payment of claims?_____. How much does the society owe the Fund?_____¥.

c) How much is the monthly salary, including cash allowances, of full-time doctors?_____ and nurses?_____ employed by the society.

d) What other remuneration, if any, is received by full-time doctors? _____, nurses? _____

8. Complaints -

a) Enter the major types of complaints received from members regarding, benefits, allowances, contributions, or other issues: ____ _____

b) How many complaints are received during an average month?_____

9. Informational Service -

a) Are copies of the Law, ordinances, regulations, and rules made available to the members?_____

b) What other methods are used by the society to give information on appeals and benefit rights to the members and their dependents? _____

10. Contact Information -

a) Date of Contact:_____

b) Persons contacted and their titles:_____

_____

c) Have previous contacts been made with this society?_____.
If so, give dates and pertinent observations:_____

_____

d) Present contact made by:_____

Date:_____

REMARKS: